Glossary of Common Terms

ADL

Activities of Daily Living. The functions or activities performed in the course of a normal day in an individual's life, including bathing, dressing, eating, mobility, transferring from one surface to another (such as from the bed to a chair), and using the toilet.

Aging and Disability Resource Centers

Aging and Disability Resource Centers provide older people, people with disabilities, and their families with information and advice about a wide range of resources available to them in their local communities.

CMO

Care Management Organization. Care Management Organizations provide long term care and health care services, coordinate the provision of other services, and promote preventive services for enrolled members.

COP

Community Options Program. A long-term support program that helps people who are elderly or disabled to live at home or in community-integrated settings typical of residential arrangements in which non-disabled persons reside. The goal of the COP is similar to the home and community-based waiver (HCBW) programs, but the COP relies only on state funds and not on Medicaid. Community Options Program funds can be used somewhat more flexibly than HCBW waiver funds to support people in the community and it emphasizes the use of informal supports to help people remain independent.

Cost-share

The maximum amount that some members are required to pay to the Care Management Organization each month to contribute to the cost of their long term care. Income, assets, and the cost of care plan services are among several factors considered in determining whether the member will be required to contribute and, if so, the maximum amount of the contribution.

Crossover claim

A Medicare-allowed claim for a dual entitlee sent to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

DHCF

Division of Health Care Financing. *Please see the definition under DHFS.*

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Health Care Financing Administration (HCFA) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and HCFA policy.

OSF

Office of Strategic Finance. In the Department of Health and Family Services (DHFS), the OSF, which includes the Center for Delivery Systems Development, is responsible for implementing Family Care pilots.

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software and Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Family Care target groups

Family Care covers adults 18 years and older with long term care needs who are any of the following:

- Elderly.
- Physically disabled.
- Developmentally disabled.

Specific target groups served vary among the pilot projects.

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Financial eligibility

Financial eligibility for Family Care means either the individual is financially eligible for Medicaid or the projected cost of the individual's care plan is more than the amount the individual is required to pay each month toward the cost of the services, based on available income and assets.

Functional eligibility

Functional eligibility for Family Care is based on the degree to which an individual can independently manage the activities of daily living (ADL) and instrumental activities of daily living (IADL).

HCBW

Home and community-based waivers. Home and community-based waivers provide Medicaid funds to help people who would be eligible for nursing home care to remain in their own homes or other community-based settings. Home and community-based waiver programs include:

- Community Integration Programs (CIP) 1A and 1B for individuals with developmental disabilities.
- CIP-II and Community Options Program — Waiver (COP-W) for elderly individuals and individuals with physical disabilities.
- Community Supported Living Arrangements (CSLA).
- Brain Injury Waiver (BIW).

HCFA

Health Care Financing Administration. An agency housed within the U.S. Department of Health and Human Services (DHHS), HCFA administers Medicare, Medicaid, related quality assurance programs, and other programs.

IADLs

Instrumental Activities of Daily Living. A range of self-maintaining activities more complex than those needed for personal care, including meal preparation and nutrition, management of medications and treatments, money management, using the telephone, arranging and using transportation, and the ability to function at the job site.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medicaid-covered

For the purposes of this guide, "Medicaid-covered" means services that are covered by Medicaid, but not including services covered by the Medicaid home and community-based waivers (HCBW) program.

Medicaid nursing home resident liability

Any income in excess of a recipient's personal needs allowance that is used to cover the recipient's cost of care in his or her nursing facility.

Medicare

A federal health insurance program for people 65 years of age or older, certain younger people with disabilities, or people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD). Medicare coverage is made up of two parts:

- Medicare Hospital Insurance (Part A) that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

- Medicare Medical Insurance (Part B) that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A.

OSF

Office of Strategic Finance. *Please see the definition under DHFS.*

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their Medicaid fee-for-service claims.

Spenddown

Similar to an insurance deductible, the spenddown amount is a set amount of medical charges that a recipient must pay out-of-pocket. The certifying agency establishes the amount for individuals who meet all Medicaid eligibility requirements except those that pertain to financial status.